Medicare Part D
Formulary Exception/Prior Authorization Request Form
Please Fax to: (866) 855-2676

Standard Request (72 hours)

Expedited Request (24 hours – must be critical to patient care)

Date of Request: ___________________________

Physician's Name: ____

Physician's DEA#: ______________________________ Specialty: ___________________________________

Phone # : ___________________________________Fax # :____

Patient's Name: ___________________________________ DOB: ____________________ Gender: _______

Patient's ID# :_______________________ Patient's Diagnosis :______________________________________

Medication Needed: ____ Strength:______________________

Quantity: ____________ Directions:______________________________________ Duration:______________

Has this patient tried other medications for this condition? (List drug, duration, results)

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Clinical rationale for selected drug usage: ____

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Is patient currently taking drug? __________________ If so, how long?_________________________________

*** All fields must be complete and legible for Review***

*** Only one medication request per form***

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